2008 Annual Enrollment Video Presentation
(for the EIP Web site 9-2-08)

1. Welcome to annual enrollment 2008. This presentation will explain insurance benefits options for 2009 and guide you through the annual enrollment process. The annual enrollment period is October 1st through October 31st, 2008. Any changes you make during annual enrollment will be effective January 1st, 2009. By January 2009, you will receive the *2009 Insurance Benefits Guide,* your primary source for comprehensive information on all the benefits programs offered through the Employee Insurance Program.

2. During the 2008 annual enrollment, you can change from one health plan to another, such as changing from the State Health Plan Standard Plan to BlueChoice HealthPlan, one of the state's HMOs.

If you are already enrolled in MoneyPlu$, you must re-enroll in the MoneyPlu$ Dependent Care and Medical Spending Accounts. You must have worked for a state insurance-covered employer for at least one year, with no break in service, to be eligible to enroll in a MoneyPlu$ Medical Spending Account.

You can increase your optional life insurance without providing medical evidence of good health.

The state's Long Term Care Program has a new plan administrator, Prudential Insurance Company.

3. In 2009 all health plans will offer behavior therapy benefits for children at age eight or younger diagnosed with autism spectrum disorder. Benefits begin after annual deductible is met and will be allowed until age 16. There is a maximum yearly benefit of $50,000.

4. We will now review your health options for 2009.

5. The first two options are the State Health Plan Standard Plan and the Savings Plan. Both Plans are administered by Blue Cross Blue Shield of South Carolina. There will be no premium increase. The Standard Plan and the Savings Plan share some common features. There are network providers that can be located online at www.southcarolinablues.com.

6. Additionally, the plans include out-of-network benefits and a pharmacy network; preventive care, mental heath and substance abuse benefits; Medi-Call and APS pre-authorization requirements; and the BlueCard program. The State Health Plan coordinates prescription drug and medical benefits. This ensures that if you are covered by more than one health plan, both plans pay their share of the cost of your care.

7. A tobacco-cessation benefit is available to any active State Health Plan Standard Plan or Savings Plan subscriber and their covered dependents. State Health Plan Standard Plan or Savings Plan subscribers may participate in the Free and Clear QUIT-FOR-LIFE program. When eligibility has been verified you will promptly be referred to a quit coach. A Free and Clear quit coach works with you to create a personalized quit plan. Contact Free and Clear at: 866-QUIT-4-LIFE or 866-784-8454.

8. *My Insurance Manger* is an online, interactive tool, available to subscribers of the Standard Plan and the Savings Plan. Visit *My Insurance Manager* by simply going to www.southcarolinablues.com. There you can review your claims status, view and print a copy of your explanation of benefits and see how much you have paid toward your annual deductible and coinsurance maximum. You can also ask a customer service representative a question through secure e-mail, locate a network provider and request an ID card.

9. We will now review the benefits for the Standard Plan.

10. When you enroll in the Standard Plan there is a $350 annual deductible for individual coverage and a $700 deductible for family coverage. Once you meet your annual deductible, the Plan pays 80 percent of allowable charges if you use an in-network provider. You will be responsible for the remaining 20 percent. If you go to an out-of-network provider, the Plan pays 60 percent of allowable charges and you will be responsible for the remaining 40 percent. Your coinsurance maximum for a network provider is $2,000 for an individual and $4,000 for a family. Out-of-network, your maximum coinsurance is $4,000 for an individual and $8,000 for a family. There is a one million dollar lifetime maximum benefit for each covered person.

11. A per-occurrence deductible is the amount you must pay before Standard Plan benefits begin. You pay a per-occurrence deductible each time you receive services in a professional provider's office, if you visit an emergency room or receive out-patient hospital services. This deductible does not apply toward your annual deductible or your co-insurance maximum. The per-occurrence deductibles are $125 for each emergency room visit (which is waived if you are admitted), $75 for out-patient hospital services (some exceptions do apply) and $10 for each visit to a professional provider's office.

12. The prescription drug program is administered by Medco. Prescription drugs are covered only when you use a network pharmacy. As a Standard Plan subscriber, show your State Health Plan ID card when you purchase prescriptions. When you purchase up to a 31-day supply, your co-payment will be $10 for Tier 1, $25 for Tier 2 and $40 for Tier 3.

If the actual cost of the drug is less than the copayment, you will pay the lower amount. There is a "pay the difference" policy. This means if you purchase a more

expensive Tier 2 or Tier 3 drug when an equivalent Tier 1 drug is available, the Plan will only cover the cost of the generic. You will pay the difference between the cost of the Tier 2 or Tier 3 drug plus the Tier 1 copayment. This policy will apply even if the doctor prescribes the medication as "dispensed as written" or as "do not substitute."

13. There is no annual deductible for prescription drugs and there is a $2,500 co-payment maximum per person. Prescription drug benefits are also subject to coordination of benefits.

14. You can order up to a 90-day supply of your prescriptions from Medco through the mail. Go to the EIP Web site, www.eip.sc.gov, and click on "Online Directories."

15. Co-payments for a 90-day supply are $25 for Tier 1 drugs, $62 for Tier 2 drugs and $100 for Tier 3 drugs.

16. If you are enrolled in the Standard Plan you may buy prescription drugs at mail-order prices at local pharmacies belonging to the "Retail Maintenance Network." You will pay the same copayment as you would through mail-order. This applies only to prescriptions filled for a 63 to 90-day supply at one of the pharmacies participating in the network.

17. You can locate a list of participating pharmacies if you go to the EIP website, www.eip.sc.gov choose "Online Directories" and you will see a link to the "State Health Plan Retail Maintenance Network." If you do not have Internet access, ask your benefits administrator to print a copy of the list, or call Medco at 800-711-3450.

18. *My Rx Choices* is an online tool available to registered users of www.medco.com. It can help you and your doctor make more economical decisions about your long-term prescriptions. Go to www.medco.com and log in. First-time users must register. There, you will find comparisons of the long-term medications you take, what you pay for them and how much you could save by using lower-cost alternatives.

19. We will now review the benefits for the State Health Plan Savings Plan.

20. The Savings Plan is designed for subscribers who are willing to take greater responsibility for their heath care, want lower premiums and would like to save for medical expenses through a Heath Savings Account.

21. The annual deductible for the Savings Plan is $3,000 if only one individual is covered and $6,000 for a family where more than one person is covered. There is no embedded deductible. This means that the family deductible is not considered met for any covered individual until the total deductible exceeds $6,000. You pay 100 percent of the allowable charges for medical and prescription costs.

22. Once the annual deductible is met, the Savings Plan begins to pay benefits like the Standard Plan. In-network, the Plan pays 80 percent of allowable charges, and you're responsible for the other 20 percent with no balance-billing. Out-of-network, the Plan pays 60 percent of allowable charges and you pay the remaining 40 percent, plus any charges above the Plan's approved amount. Only the 40 percent of approved charges apply toward your coinsurance maximum.

When you use a network provider, the coinsurance maximum is $2,000 for an individual and $4,000 for a family. Out-of-network, the coinsurance maximum is $4,000 for an individual, $8,000 for a family. There is a one million dollar lifetime maximum for each covered person.

23. The Savings Plan has other benefits such as no per-occurrence deductibles, reimbursement for an annual flu shot and eligibility to contribute to a Health Savings Account.

24. An annual physical is an additional benefit for Savings Plan subscribers. And, it's free! Annual physicals include a preventive comprehensive examination, a complete urinalysis, an EKG, a fecal occult blood test, a lipid panel every five years and a pap smear for women, ages 18 through 65.

25. However, there are restrictions with the Savings Plan. Restrictions include chiropractic benefits that are limited to $500 per person after the annual deductible is met. Prescriptions for non-sedating antihistamines and drugs for erectile dysfunction are not covered under the Savings Plan. This means that you will pay 100 percent of the drug cost and the cost will not apply towards your annual medical deductible.

26. A Health Savings Account or HSA, coupled with the Savings Plan, can help you save money for qualified medical expenses. This tax-sheltered account is portable, which means you can take it with you when you leave employment or retire. To contribute to a Health Savings Account, you must be covered by a "high deductible health plan" such as the State Health Plan Savings Plan. You cannot contribute to a Health Savings Account if you are covered by any other type of health plan, including Medicare.

27. For 2009, contributions cannot exceed $3,000 for an individual or $5,950 for a family. Individuals age 55 and older may contribute an additional $1,000 for 2009.

28. Money deposited in your HSA is carried forward from year-to-year. Eligible contributions are tax-free if payroll deducted. Interest accumulates tax-free! If you choose not to have your contributions payroll deducted, HSA contributions can be direct deposited and deducted on your tax return.

29. Your spouse and dependents don't have to be covered by the State Health Plan Savings Plan or other high deductible health plan to withdraw funds from your HSA.

However, be sure to keep your receipts and other documentation when you use your Health Savings Account in case the IRS asks for them.

30. There is a penalty if you use the funds for non-qualified expenses and the funds will be subject to taxes and penalties. A penalty will apply unless the subscriber becomes disabled, enrolls in Medicare or dies.

31. For additional information about Health Savings Accounts, visit the IRS website at www.irs.gov or refer to the "MoneyPlu$ Tax-favored Accounts Guide" that is available on the EIP Web site at www.eip.sc.gov.

32. To activate your HSA visit the EIP Web site and click on the links at the top of the home page. Then choose "open HSA bank account." If you don't have internet access, see your benefits administrator. To withdraw money, funds must be in your account. Money does not advance to you. That means the account is just like a checking account -- if you have no money in the account and you write a check, the check is not valid. When you withdraw funds from your Health Savings Account you don't have to pay taxes for qualified expenses.

33. The HSA administration fee is $12 per year or $1 deducted monthly. Or, you can pay an upfront $10 administration fee when you open your account. This fee is waived if the account's balance reaches $2,500. Once enrolled, NBSC will issue you an unlimited-use VISA® check card. If you prefer to withdraw money from your HSA by using your VISA® check card, there is a $.35 fee per check written.

34. Health Savings Account subscribers may also enroll in a "Limited Use" Medical Spending Account for an additional $3.50 a month. You can place up to $5,000 in this account, but that money can only be used for vision care or dental expenses. You must be employed for one year to be eligible for a "Limited Use" Medical Spending Account."

35. Now, we will begin to review benefits offered through the State Health Plan's HMOs or Health Maintenance Organizations.

36. With any HMO you must choose a primary care physician. This doctor will take care of all of your health care needs. Your primary care physician may refer you to a specialist for certain conditions; but, you must go through your primary care physician to be referred to a specialty care doctor or group. You must choose an HMO in the area where you work or live. HMOs provide coverage for qualified emergencies outside of service areas. However, HMOs do not provide non-emergency services outside of their network. So, read HMO materials carefully before making a health plan selection.

37. The first HMO we are going to review is *BlueChoice HealthPlan*. *BlueChoice HealthPlan* is available in all South Carolina counties.

38. There is a $250 annual deductible for an individual and $500 for a family. Generally, the deductible applies to inpatient, outpatient and emergency services, including those provided in a hospital and in other settings, such as admission to skilled nursing facilities. Ambulance services; durable medical equipment; and hospital, home health care and hospice care services are applied to your *BlueChoice HealthPlan* deductible. The Plan's deductible does not apply to office visits, routine physicals, well-child care and prescription drug benefits.

Once *BlueChoice HealthPlan's* annual deductible is met, the HMO pays 90 percent of allowable charges. Your coinsurance will be 10 percent.

39. In addition to an annual deductible, the subscriber is responsible for copayments. There is a $100 outpatient hospital copay, a $125 emergency room copay and a $200 inpatient hospital copay. The deductible does not apply to these facility charges, but may apply to related professional charges. These copayments do not apply toward the deductible. Coverage is provided at 90 percent after the copayments are paid.

40. The coinsurance maximum is the most an individual or family will pay for covered services. For 2009, the coinsurance maximum for *BlueChoice HealthPlan* is $1,500 for an individual and $3,000 for a family. The annual deductible and copayments do not apply to the coinsurance maximum.

41. Physical therapy, speech therapy and occupational therapy are covered after your annual deductible is met. Then, the plan pays 90 percent of allowable charges -- you pay the other 10 percent. There is a twenty-visit per "therapy" limit per plan year. *BlueChoice HealthPlan's* human organ transplant benefit lifetime maximum is $250,000.

42. Other *BlueChoice HealthPlan* copayments are $15 for primary care physician or OB-GYN visits, $30 for specialists and $35 for urgent care. The plan pays 100 percent of allowable charges after your copayment.

43. *BlueChoice HealthPlan* provides prescription drug coverage. You must use a network participating pharmacy when purchasing your medications. Benefits are not payable if you use a pharmacy outside of the network. *BlueChoice HealthPlan* subscribers can also purchase long-term prescriptions through the mail.

44. In-network copays for up to a 31-day supply are $7 for generic brands, $35 for preferred brands, $55 for non-preferred brands and $100 for specialty pharmaceuticals. Mail-order copayments for a 90-day supply are $14 for generic brands, $70 for preferred brands and $110 for non-preferred brands.

45. *BlueChoice HealthPlan* subscribers may participate in the Free and Clear QUIT-FOR-LIFE tobacco-cessation program. The program is available to any active *BlueChoice HealthPlan* subscriber and their covered dependents, age 18 or older. When eligibility

has been verified you will promptly be referred to a quit coach. A Free and Clear quit coach works with you to create a personalized quit plan. Contact Free and Clear at: 866-QUIT-4-LIFE or 866-784-8454.

46. CIGNA HMO is available in all South Carolina counties except Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.

47. With CIGNA HMO there is no annual deductible. The Plan pays 80 percent of covered charges after you pay a copayment. Copays are $250 for outpatient services and $500 for inpatient hospital services. If you have to go to the emergency room, you will pay a $100 copayment. Then CIGNA will pay 100 percent of allowable charges.

48. There is a coinsurance maximum of $2,000 for an individual and $4,000 for a family.

49. Visits to a primary care physician or an OB-GYN require a $15 copayment. Additionally, there is a $30 copay for specialists and for outpatient mental health and substance abuse services.

50. CIGNA covers short-term rehabilitation therapy and chiropractic services. There is a $30 copay for these services and the plan allows twenty visits per “therapy” annually.

51. CIGNA HMO provides prescription drug coverage. You must use a network pharmacy when purchasing your prescriptions. Copayments at network pharmacies for up to a 30-day supply are $7 for generic brands, $25 for preferred brands and $50 for non-preferred brands. Mail-order is also available for a 90-day supply. Copayments for prescriptions by mail are $14 for generic brands, $50 for preferred brands and $100 for non-preferred brands.

52. Tobacco-cessation benefits are also available to CIGNA HMO subscribers. Call CIGNA Healthcare at 800-244-6224 for information on their Plan’s tobacco-cessation benefits.

You can also find out about other wellness programs available through CIGNA's discount program, *Healthy Rewards*, by calling customer service or accessing the CIGNA Website.

53. Next are the 2009 health premiums for active employees.

54. The premiums represented in this slide are monthly premiums. If you are paid 24 times per year, divide the figures on this slide by two to determine the amount that will be payroll deducted. The premiums here are for employees of state agencies, universities or school districts. The 2009 premiums also can be found in your *2008 Insurance Advantage* newsletter. If you are employed by an optional employer, such as city, county or a local subdivision, please contact your benefits administrator for your premiums.

55. You can change health plans during annual enrollment.

56. If you didn't enroll in one of the state's health plans last fall during the 2007 open enrollment, you cannot enroll in a health plan nor can you enroll any dependents in your health plan of choice during the 2008 October annual enrollment. However, you can change from one of the state's health plans to another one during this year's annual enrollment, but you must complete an NOE to make a change. A real plus is that you can do this through *MyBenefits,* the state's online enrollment system.

57. MoneyPlu$ is the state's "tax-favored account" program, administered by Fringe Benefits Management Company, or FBMC.

58. First-time MoneyPlu$ subscribers must see their benefits administrator to enroll. Current MoneyPlu$ spending account participants can now re-enroll online.

59. Active employees can enroll or re-enroll in MoneyPlu$ Dependent Care and/or Medical spending accounts. An employee must be continuously employed for one year, by January 1st, to be eligible to enroll in a Medical Spending Account.

60. Re-enrolling online is easy. Visit www.my FBMC.com. You can re-enroll online from October 1st through October 31st. If this is your first time visiting the site, you will need to register. For more information, call FBMC Customer Service at: 800-342-8017.

61. There will be no change in the MoneyPlu$ pre-tax premium feature for health, state dental and Dental Plus, and Optional Life. The administrative fee of $.28 will remain the same.

62. Next, we will discuss the MoneyPlu$ Dependent Care Spending Account features.

63. The maximum amount you can contribute in the Dependent Care Spending Account will be $5,000 per family for the year and the monthly administrative fee will be $3.50 per month.

64. Dependent Care Spending Account participants must incur expenses by December 31, 2009. The deadline for filing Dependent Care Spending Account claims is March 31st, 2010.

65. MoneyPlu$ Medical Spending Accounts have some very valuable benefits.

66. Subscribers enrolled in a Medical Spending Account, or MSA, may contribute up to $5,000 to the account per year. The administration fee for this account will also be $3.50 monthly. An employee must be employed by a participating employer

continuously for one year to be eligible to participate in a Medical Spending Account. The deadline for filing for Medical Spending Account expenses is March 31, 2010.

67. A grace period allows you to incur expenses through March 15th, 2010, provided there are funds remaining in your account from 2009 and the account is active on December 31st, 2009. This policy applies to Medical Spending Accounts and to "limited use" Medical Spending Accounts. Don't wait to submit 2009 MSA claims and documentation (particularly if you have begun submitting 2010 claims).

68. Remember, during the grace period MSA claims for services delivered in 2010 received during the grace period will be paid with unspent 2009 money first. So if you wait to file claims for 2009 expenses, there may be no money left in your account. This means you want to be sure that all of your 2009 claims are filed first before submitting 2010 claims.

69. Subscribers enrolled in a Medical Spending Account, and who have an EZ REIMBURSE®MasterCard®, can use the card for eligible medical expenses if the service provider has an EZ REIMBURSE®MasterCard® terminal. Eligible medical expenses such as copays and deductibles are subtracted at the point-of-sale. FBMC will mail your EZ REIMBURSE®MasterCard® to your home, unless you are currently enrolled. If you are already enrolled, keep the card you have.

70. The annual fee for the EZ REIMBURSE®MasterCard® is $10 and will be deducted from your Medical Spending Account. This card is not available if you are enrolled in a "Limited Use" MSA.

71. January 1st, 2009 you will not be able to use your EZ REIMBURSE® MasterCard® at any general merchandise store pharmacy or at any grocery store pharmacy that has not coded its prescriptions and eligible over-the-counter items.

72. Many general merchandise store pharmacies and grocery store pharmacies have the capability to electronically identify prescriptions and eligible over-the-counter items electronically. EZ REIMBURSE® MasterCard® and other medical spending account card programs must be able to electronically identify the items. Visit the FBMC Web site at www.myFBMC.com for a list.

73. If you do not choose to use the EZ REIMBURSE® MasterCard®, you can still use a Medical Spending Account and get more out of your paycheck. You will have to file paper claims to FBMC by fax or regular mail. The money you are reimbursed can be deposited directly into your checking account. There is an Internet or Integrated Voice Response system available 24-hours-a-day, seven-days-a-week.

74. The rule, "use it or lose it," applies if you have an EZ REIMBURSE® MasterCard®. That is if you don't use the money in your Medical Spending Account, you will lose that money if claims are not filed by March 31 of the following year.

75. Life Insurance Programs are administered by The Hartford.

76. During annual enrollment, an active employee can enroll in or increase their Optional Life Insurance coverage in $10,000 increments, up to $50,000, without providing medical evidence of good health. Subscribers may increase coverage to a amount higher than $50,000, in $10,000 increments, up to $500,000, by providing medical evidence of good health. Employees may also decrease or cancel coverage.

77. Any changes you make during annual enrollment will go into effect January 1st, 2009, provided that you are actively at work. You are also considered actively at work on any regularly scheduled vacation day or holiday if you are actively at work the preceding workday.

78. You can enroll or increase Dependent Life Spouse Insurance coverage by providing medical evidence of good health. Coverage cannot exceed 50 percent of the employee's Optional Life benefit amount, or $100,000, whichever is less. Some exceptions apply.

79. The Long Term Care insurance program has a new plan administrator.

80. Prudential Insurance Company will be the new plan administrator beginning January 1, 2009. An open enrollment will occur early in 2009.

81. Employees can make annual enrollment changes online.

82. Visit the EIP Web site at www.eip.sc.gov and click on *"MyBenefits,"* EIP's online enrollment system. *"My Benefits"* is available to active employees and retirees of all participating groups. Updates or changes made are sent to EIP electronically.

83. It is accessible anytime wherever you have Internet access. It is a subscriber-driven system. With *"MyBenefits,"* you can see your benefits statement online, change your contact information, add or change your beneficiaries and make annual enrollment changes.

84. To enroll in *"MyBenefits"* you will need your Benefits Identification Number, your Social Security Number and your date of birth.

85. To make changes effective January 1, 2009, simply go to www.eip.sc.gov, click on *"MyBenefits"* on the left side of the page and select "Registration." Then you can make changes that are eligible during annual enrollment.

86. Annual enrollment is October 1 through 31, 2008. Remember, you are responsible for your benefits. During annual enrollment, if you want to make an eligible change, you must complete an NOE by October 31, 2008. Nothing is automatic! Changes made during annual enrollment will be effective January 1, 2009.

To contact EIP call

803-734-0678 in the Greater Columbia Area or
888-260-9430 toll-free outside of Columbia

The EIP website is www.eip.sc.gov.

87. The information in this overview is not meant to serve as a comprehensive description of the benefits offered by the Employee Insurance Program. Please consult your *Insurance Benefits Guide, Insurance Advantage newsletter* and literature from the various HMOs offered in your service area for additional information.

88. BENEFITS ADMINISTRATORS AND OTHERS CHOSEN BY AN EMPLOYER WHO MAY ASSIST WITH INSURANCE ENROLLMENT AND ADJUSTMENTS, RETIREMENT OR TERMINATION AND RELATED ACTIVITIES ARE NOT AGENTS OF THE EMPLOYEE INSURANCE PROGRAM AND ARE NOT AUTHORIZED TO BIND THE EMPLOYEE INSURANCE PROGRAM.

Thank you for joining us for today's presentation. This has been a production of the South Carolina Budget and Control Board's Employee Insurance Program.